No. 14-181

In The
Supreme Court of the United States

ALFRED J. GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

REPLY BRIEF FOR PETITIONER

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ARGUMENT

The Court should grant the petition to return clarity and predictability to an area – ERISA preemption – that has a profound impact on state policies and the federal-state balance.

First, the question presented is one of undeniable national importance. Both Vermont and the amici States have explained how the decision below, if not immediately addressed by this Court, will undermine state health care policies across the nation. Pet. 26-35; Amicus Br. N.Y. et al. 4-8.

Second, the decision below conflicts with relevant decisions of this Court and has already been sharply criticized by the Sixth Circuit. Pet. 6-25; Amicus Br. N.Y. et al. 8-14. Liberty Mutual argues at length that the Second Circuit panel majority correctly interpreted this Court's ERISA preemption cases. Opp. 14-27. Conspicuously absent, however, is any mention that the U.S. Department of Labor – the federal agency charged with administering ERISA – filed an amicus brief in the Second Circuit taking the opposite position. U.S. Ct. App. Br. 5 (Vermont's law "does not relate to ERISA plans in any way that dictates benefit choices or interferes with plan administration or structure."). The federal government, seven States, another court of appeals, and the dissenting judge below all disagree with the Second Circuit's sweeping expansion of ERISA preemption. Nothing short of clarification by this Court will resolve this confusion.

Indeed, recognizing the strength of Vermont's petition on the merits, Liberty Mutual focuses instead on the unremarkable substitution of the relevant government official as petitioner. This invented jurisdictional objection should not distract from the need for this Court's immediate review. Vermont is familiar with its own laws and knows who is running the State's database. The Chair is the right party and was properly substituted under this Court's Rule 35.3.

I. As confirmed by the States' amicus brief and the participation of the United States below, this case presents an issue of exceptional importance that warrants immediate review.

The Second Circuit's broad expansion of ERISA preemption in this case undermines a critical tool that States use to improve the quality of health care for their citizens and reduce its cost. That is not just Vermont's view. The multistate amicus brief filed by New York – a State also directly impacted by the ruling below – urges this Court's review. As the amici explain, the "decision below will diminish the ability of States to improve the quality and affordability of the health-care services available to their residents." Amicus Br. N.Y. et al. 2. All told, sixteen States have or are developing all-payer claims databases to "audit the cost and effectiveness of the health care provided within their borders." *Id.* at 1. The Second Circuit's holding creates a gaping hole in those databases,

because it cuts out data for tens of millions of Americans covered by self-insured plans. Michael Brien et al., *Self-Insured Benefit Plans,* at 21.[1]

The States' interest is substantial, but so too is that of the federal government. The U.S. Department of Labor, which enforces ERISA, appeared as amicus below and argued against preemption. U.S. Ct. App. Br. 5-30. Liberty Mutual, like the Second Circuit panel majority, makes no mention of the government's position. The fact that the federal government devoted its resources to an amicus filing that supported Vermont and the district court confirms the importance of this issue. *See* Pet. App. 38-39 (Straub, J., dissenting) (relying in part on Department's position to conclude "the Vermont statute is not of the type that Congress intended to preempt"). And the fact that the federal government has voluntarily agreed to provide its claims data to Vermont shows that federal policymakers also recognize the value of comprehensive health care data.[2]

The opposition suggests that States do not need data from self-insured plans. But the States understand their own programs and policy objectives better than Liberty Mutual does. And the States' position is

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[1] Available at: http://www.dol.gov/ebsa/pdf/acaselffundedhealthplansreport032811.pdf.

[2] While this case was pending on appeal, the federal Centers for Medicare and Medicaid Services agreed to provide its claims data for Vermont's database. *See* Pet. 22 n.3.

unambiguous: omitting self-insured plans "create[s] significant and serious gaps" in the data, undermines the accuracy and "integrity" of a database, and "significantly diminish[es] the ability of States with APCD laws to regulate health care through the evidence-based approaches they have elected." Amicus Br. N.Y. et al. 7-8. Liberty Mutual cannot reasonably dispute these concerns. The majority of Americans who receive health insurance coverage from their employers are covered by self-insured plans. *See* Kaiser Family Foundation, *Employer Health Benefits 2013 Survey*, at 176.[3] An *all-payer* claims database that omits self-insured plans cannot be considered accurate or comprehensive.

With no little irony, Liberty Mutual suggests that States should rely on voluntary reporting. Liberty Mutual, with 80,000 plan members, Pet. App. 50, is not offering to report its data voluntarily. And no credible statistician would prefer a self-selected, incomplete data set to an accurate one. The States that have elected to build these databases want to see the full picture, not a jigsaw puzzle with missing pieces.

Likewise, the notion that doctors and hospitals can provide the data reflects Liberty Mutual's poor grasp of the function and design of these databases. Unlike providers, insurers and third-party administrators maintain standardized claims data. And only

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[3] Available at: http://kff.org/private-insurance/report/2013-employer-health-benefits/.

these payers can provide accurate information. Providers often do not know the final amounts paid by plans, which may reflect coordination of benefits or coverage reversals. Doctors and hospitals do not have most prescription drug claim information, which is a substantial part of health care costs.

The Court should disregard Liberty Mutual's unsupported – indeed, unscientific – position that States can do just as well with incomplete and inadequate information. One suspects that Liberty Mutual's own actuaries and economists are not so cavalier about the information they use to set insurance rates and fix reserves. The States take seriously their obligation to provide for the welfare of their citizens and have every right to seek critical information needed to support effective health care reforms.

That is why review is needed now. Accurate information is vital for rational policy-making and effective, evidence-driven health care regulation. Health care is not an issue for the future. It is a crisis today. Costs have been rising at an unsustainable rate for years. Health care spending dominates state budgets. The federal government's role in health care reform remains contested. *See King v. Burwell*, No. 14-114 (*cert. granted* Nov. 7, 2014). The States and the lower courts need clear guidance on the scope of ERISA preemption and the room States have to pursue innovative policies that serve the needs of their citizens.

II. The Second Circuit's sweeping expansion of ERISA preemption creates an urgent need for this Court's review.

Liberty Mutual's extended treatment of the merits does nothing to rebut the case for this Court's review. In fact, it does the opposite.

First, the Second Circuit's decision in this case departs so substantially from this Court's precedents that even Liberty Mutual does not defend its reasoning. Instead, Liberty Mutual re-writes the decision to avoid its undesirable consequences. It describes the ruling as limited to "reporting of information about core ERISA activities," Opp. 26, and contends that other state reporting requirements would not be affected, *id.* at 31-32. To the contrary, the majority broadly defined reporting as "plan record-keeping, and filing with a third-party," and held that ERISA tolerates only a "slight" burden on what it deemed a "core ERISA function." Pet. App. 23-24. The dissent criticized the majority for "giving the term reporting its broadest meaning." Pet. App. 32-33 (Straub, J., dissenting). Under the majority's flawed approach, any requirement that a plan keep or provide information would be at risk if a court viewed it as too "time-consuming" or more than slightly "burdensome." Pet. App. 24-25.

Liberty Mutual similarly tries to avoid the broad sweep of the Second Circuit's reasoning by positing that Vermont's reporting requirements involve "plan administration," whereas other reporting requirements

do not. But that approach, again, contradicts the Second Circuit's insistence that *all* "reporting" is a "core ERISA function." Pet. App. 23-24. Moreover, Liberty Mutual does not explain why Vermont's reporting requirement involves "plan administration" any more than other commonplace reporting requirements, including reports related to taxes paid on health care claims, *Self-Ins. Inst. of America, Inc. v. Snyder*, 761 F.3d 631, 638-39 (6th Cir. 2014) (*SIIA*);[4] reports to the regulators of health care services, *see* Pet. 32; and reports by other plan-run services like day care centers and apprenticeship programs, *see* Pet. 34.

It is not surprising that Liberty Mutual is unwilling to defend the Second Circuit's broad standard. If the mere providing of information is a core ERISA concern, then numerous state laws governing public health and safety are potentially preempted. *See* Pet. 31-35. The Second Circuit's "literal approach to preemption," *SIIA*, 761 F.3d at 639, and misplaced focus on unproven administrative burdens cannot be reconciled with this Court's precedents. Pet. 16-25; *see De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *cf. Cal. Div. Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 355 (1997) (Scalia, J., concurring) ("The statutory text

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[4] Supreme Court Docket No. 14A373 (granting extension of time to file petition).

provides an illusory test, unless the Court is willing to decree a degree of pre-emption that no sensible person could have intended."). As the Sixth Circuit explained in *SIIA*, "ERISA guarantees uniformity only with regard to the administration of employee benefit plans," and does not preempt record-keeping and reporting requirements that do not "change[ ] or interfere[ ] with plan administration." 761 F.3d at 636-39 (quotation omitted).

Second, Liberty Mutual's fourteen-page argument on the merits merely confirms the need for this Court's review. Liberty Mutual believes the lower court is correct, but it cannot change the fact that the federal government, seven States, the dissenting judge below, and the Sixth Circuit all disagree. The Second Circuit rejected without comment or explanation the considered views of the federal agency that enforces ERISA. The panel split sharply over basic matters like the application of the presumption against preemption and the purposes of ERISA's reporting provisions. *Compare* Pet. App. 18 n.8, 23-24 *with id.* at 33-34, 37-38 (Straub, J., dissenting). This uncertainty and confusion can only be resolved by this Court.

The Second Circuit's return to an unduly broad and literal understanding of ERISA preemption is a matter of grave concern to the States. Twice before, this Court has stepped in and cabined the Second Circuit's approach to ERISA preemption. *De Buono*, 520 U.S. at 812-13; *Travelers*, 514 U.S. at 653-54. The Court should do so again, and reaffirm that nothing

in ERISA "indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661.

III. Vermont's routine substitution of a public official raises no jurisdictional question.

The petition was properly filed by the state official responsible for administering and enforcing the State's program. The Vermont Legislature transferred responsibility for the database, called VHCURES, from the Department of Financial Regulation to the Green Mountain Care Board, an independent state agency. *See* 2013 Vt. Acts & Resolves, No. 79 ("Act 79"), § 40 (Reply App. 25-33); Vt. Stat. Ann. tit. 18, §§ 9373, 9374. Vermont adhered to Supreme Court Rule 35.3 by substituting the Chair of the Board for the Commissioner of the Department.

Liberty Mutual's objection to this routine substitution is easily dispatched. In its complaint, Liberty Mutual seeks a declaratory judgment that the database statute and rule "are preempted by ERISA to the extent they require the reporting, production, or disclosure" of information by the plan. Reply App. 16. Liberty Mutual also seeks a permanent injunction against future enforcement. *Id.* at 17. Given these requests for prospective relief, the official that presently administers and enforces the statute is the proper defendant.

The Board Chair is that defendant. Act 79 leaves no doubt that the Legislature transferred both administrative responsibility and enforcement authority to the Board. The word "commissioner" is crossed out and replaced by "Board" at least twenty-two times in the relevant section. Act 79, § 40 (Reply App. 25-33). The Board is given authority over reporting requirements and confidentiality standards. *Id.* (amending § 9410(d), (f), (h), (j)(2)). Staffing and funding were shifted to the Board, with the former administrative division abolished. *Id.* §§ 50(a), 52(e) (Reply App. 33-34). Rulemaking power now rests with the Board. *Id.* § 40 (amending § 9410(j)(2)) (Reply. App. 32) ("The ~~commissioner~~ Board may adopt rules. . . ."). And the Board has taken over enforcement authority for the database, including authority to impose financial penalties for violations of the statute. *See id.* (amending § 9410(g) (Reply App. 28-29). That power is "in addition to," *id.*, the Board's general subpoena power. *See* Vt. Stat. Ann. tit. 18, § 9374(i)-(j) (Reply App. 23-24); *id.* § 9412 (additional powers).

Given the Legislature's comprehensive transfer of authority to the Board, Liberty Mutual's objection to the substitution of the Chair as petitioner is baseless. This Court's Rule 35.3 – nearly identical to Fed. R. Civ. P. 25(d) and Fed. R. App. P. 43(c)(2) – provides that "[w]hen a public officer who is a party to a proceeding in this Court in an official capacity dies, resigns, or otherwise ceases to hold office, the action does not abate and any successor in office is automatically substituted as a party." Sup. Ct. R. 35.3. As

Liberty Mutual acknowledges, Opp. 11 n.4, the substitution rule applies "when a particular function is transferred from one office to another office." 7C C. Wright et al., Federal Practice and Procedure § 1960 (2014); *see Top Flight Entm't, Ltd. v. Schuette*, 729 F.3d 623, 630 n.1 (6th Cir. 2013) (recognizing automatic substitution of state official after transfer of authority); *Air Line Pilots Ass'n v. Civil Aeronautics Bd.*, 750 F.2d 81, 87, 89 (D.C. Cir. 1984) (transfer between federal agencies); *cf. Wright v. Council of Emporia*, 407 U.S. 451, 458 n.10 (1972) (noting district court had treated city officials as "successors" to county officials in school desegregation case).

Because substitution is automatic, the Chair had no obligation to intervene, and it makes no difference that the caption was not amended below. *See* Opp. 13 & nn.6-7. When the law changed, the Chair was "substituted automatically . . by operation of" the rule. *Schuette,* 729 F.3d at 630 n.1. "[N]o consequences follow from the failure to enter" an order of substitution. 7C C. Wright et al., Federal Practice and Procedure § 1960; *see* Sup. Ct. R. 35.3 ("any misnomer not affecting substantial rights of the parties will be disregarded").

While Liberty Mutual suggests that "relevant" enforcement authority was not transferred, Opp. 12, all it has shown is that the subpoena directed to its third-party administrator in 2011 was issued by the Commissioner. Of course it was, because that was the Commissioner's role in 2011. And of course the Legislature did not remove the Commissioner's general

subpoena power (Vt. Stat. Ann. tit. 8, § 13(b)) when it transferred the database to the Board. The Commissioner still needs, and still has, subpoena power for other purposes, but she does not oversee the database or enforce the reporting obligation.[5]

What matters for purposes of the automatic substitution rule is not what happened in 2011, but what would happen now. And now, the Board, not the Commissioner, would enforce compliance with the database statute and regulation. The Chair has authority to issue subpoenas, compel production of documents, and sanction a party's failure to comply. Vt. Stat. Ann. tit. 18, § 9374(i)-(j) (Reply App. 23-24) (conferring subpoena power and authorizing fines for noncompliance); *id.* tit. 3, § 809a (court enforcement of subpoenas). The Legislature gave the Board

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[5] Liberty Mutual makes two points about the Commissioner's subpoena power, neither of which are relevant. First, Liberty Mutual suggests that the Chair does not have the "same" power as the Commissioner to sanction noncompliance, Opp. 12, but fails to mention that the Chair has identical authority to impose fines and seek court enforcement of subpoenas. *Compare* Vt. Stat. Ann. tit. 18, § 9374(j) (Chair may impose penalty up to $2,000.00 per day, seek court enforcement, and recommend license suspension) *with id.* tit. 8, § 13(b) (same, except Commissioner may suspend "authority to do business"). Second, while the Commissioner's subpoena statute lists, among other provisions, the statutory chapter (Chapter 221) that includes the database, the Commissioner has *other* responsibilities in that chapter. *See, e.g., id.* tit. 18, § 9414a (health insurers' annual reports). The Commissioner's Chapter 221 authority is, moreover, limited to "the execution of all laws vested in the Department by this chapter." *Id.* § 9404(a).

express authority to impose monetary penalties for violations of the database statute. *Id.* tit. 18, § 9410(g) (Pet. App. 95). The fact that the 2011 subpoena was not issued by the Board is irrelevant, because enforcement of the 2011 subpoena is not "at the core of this dispute." Opp. 10. Liberty Mutual challenges any prospective enforcement against its plan. That is what the complaint says. Reply App. 16-17. And that is what Liberty Mutual requested below: "remand with instructions that the district court enter a declaratory judgment that ERISA preempts the Vermont Statute and Regulation to the extent that they require the Plan's claims data to be reported to Vermont." Liberty Mutual Ct. App. Br. 41. The relief sought by Liberty Mutual could no longer be entered against the Commissioner.

A complaint filed today would name the Chair as the defendant. That alone confirms that the Chair is the proper party. And Liberty Mutual surely knows this. The change to Vermont law was plain and the party substitution routine. Liberty Mutual has invented a jurisdictional objection. That it did so, and led with this weak argument as its principal objection to the petition, can only be explained as an effort to distract attention from the merits.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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UNITED STATES DISTRICT COURT
DISTRICT OF VERMONT

Liberty Mutual Insurance Company Plaintiff, v. Stephen W. Kimbell, in his capacity as the Vermont Commissioner of Banking, Insurance, Securities and Health Care Administration, Defendant.	)	2:11-cv-204

VERIFIED COMPLAINT FOR DECLARATORY JUDGMENT AND OTHER RELIEF

(Filed Aug. 12, 2011)

Plaintiff Liberty Mutual Insurance Company ("Liberty Mutual"), through its undersigned attorneys, for its verified complaint against defendant Stephen W. Kimbell ("Defendant") in his capacity as the Vermont Commissioner of Banking, Insurance, Securities and Health Care Administration ("BISHCA"), states as follows:

JURISDICTION AND VENUE

1. This is an action pursuant to the Declaratory Judgment Act, 28 U.S.C. § 2201, *et seq.* and the Employee Retirement Income Security Act of 1974

("ERISA"), 29 U.S.C. § 1001 *et seq.* This case involves an actual controversy between the parties as to whether ERISA preempts a state statute and regulation requiring the disclosure to BISHCA of confidential health care information and records of medical treatment provided to private individuals in Vermont.

2. This Court has subject matter jurisdiction under both ERISA Section 502(e)(1), which provides the Court with exclusive jurisdiction to hear suits under Section 502(a)(3), and 28 U.S.C. § 1331.

3. Venue in this Court is proper under Section 502(e)(2) of ERISA because this is the District where the threatened violation of ERISA will take place and because the Defendant resides or may be found in this District.

PARTIES

4. Plaintiff Liberty Mutual is an insurance company organized under the laws of the Commonwealth of Massachusetts. Liberty Mutual is a wholly owned subsidiary of Liberty Mutual Group Inc. Liberty Mutual's principal offices are located at 175 Berkeley Street, Boston, Massachusetts 02116. Liberty Mutual has employees and offices in Vermont and conducts business in Vermont.

5. Defendant Stephen W. Kimbell is Commissioner of BISHCA for the State of Vermont, and is named as Defendant in that capacity. Pursuant to Vermont statutory authority, BISHCA has promulgated

Regulation H-2008-01 ("Regulation"), which generally requires that private health care data and records of individuals' medical treatment be provided to BISHCA. The Regulation is intended to implement the creation of a "unified health care data base" pursuant to 18 V.S.A. § 9410. The Regulation states that it was "issued pursuant to the authority vested in the Commissioner of" BISHCA.

BACKGROUND AND FACTS

A. Liberty Mutual's ERISA-Governed Employee Welfare Benefit Plan and Its Third Party Administrator

6. Approximately 54 years ago, Liberty Mutual established the Liberty Mutual Medical Plan (the "Plan") for the benefit of its employees. The Plan provides a broad range of medical care benefits to Liberty Mutual's employees and their beneficiaries. As of June 30, 2011, the Plan provides medical benefits to 84,711 persons throughout the United States, including 32,933 employees of Liberty Mutual Group Inc. and its subsidiaries, as well as employees' families and company retirees. Of these people, 137 are in Vermont, including all company employees in Vermont and their families. Liberty Mutual does not offer the right to participate in the Plan to a Vermont resident unless such individual is an employee of Liberty Mutual Group Inc., or one of its participating subsidiaries, a qualifying family member of such an employee, or an eligible company retiree.

7. The Plan is an employee welfare benefit plan governed by ERISA. *See* ERISA Section 3(1), codified at 29 U.S.C. § 1002(1). Liberty Mutual was at all times relevant hereto a "named fiduciary" and "plan administrator" of the Plan within the meaning of Section 3 of ERISA, 29 U.S.C. § 1002. Liberty Mutual Group Inc. is the "Plan Sponsor" within the meaning of Section 3 of ERISA, 29 U.S.C. § 1002.

8. The Plan provides medical benefits that are self-insured by Liberty Mutual Group Inc., meaning that Liberty Mutual Group Inc. pays all benefits provided under the Plan from its own general assets. Blue Cross Blue Shield of Massachusetts, Inc. ("BCBSMA" or the "TPA") is the Plan's third party administrator, and it administers the medical claims and associated confidential medical records of Plan participants and beneficiaries. BCBSMA is also in possession of, and on an ongoing basis continues to receive, confidential and private medical data and records involving Plan participants and beneficiaries.

B. The Pertinent ERISA Provisions

9. ERISA is a comprehensive federal statute that regulates private employee benefit plans in order to provide protection to plan participants and beneficiaries. *See Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002); http://www.dol.gov/dol/topic/health-plans/erisa.htm (last visited August 11, 2011). One of the primary purposes of ERISA is to provide for the "uniform national treatment" of

employee benefit plans. *Arnold v. Lucks,* 392 F.3d 512, 519 (2d Cir. 2004) (citing *Yates Profit Sharing Plan v. Hendon,* 124 S. Ct. 1330, 1331 (2004)).

10. "ERISA expressly preempts 'any and all State laws insofar as they may now or hereafter relate to any employee benefit plan' covered by the statute." *Geller v. County Line Auto Sales, Inc.,* 86 F.3d 18, 22 (2d Cir. 1996) (citations omitted). "The express preemption provisions of ERISA are deliberately expansive. . . . [and] are among the broadest that can be found in the law." *Id.*

11. Section 404 of ERISA governs how fiduciaries of ERISA-governed plans are to behave. *See generally* ERISA § 504, codified at 29 U.S.C. § 1104. Section 404(a)(1)(A) of ERISA provides that a plan fiduciary, like Liberty Mutual, "shall discharge his duties with respect to a plan *solely in the interest of the participants and beneficiaries* and . . . *for the exclusive purpose* of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." ERISA § 404(a)(1)(A), codified as 29 U.S.C. § 1104(a)(1)(A) (emphasis added). Accordingly, ERISA forbids Liberty Mutual, a Plan fiduciary, from using the Plan for any purpose other than to provide benefits to Plan participants and beneficiaries.

12. In addition, ERISA provides "detailed reporting and disclosure requirements." *Massachusetts v. Morash,* 490 U.S. 107, 118 (1999); *see* 29 U.S.C. §§ 1023-1030. Part 1 of Subtitle B of ERISA sets forth

the reporting and disclosure duties of an administrator of a large employee welfare benefit plan such as the Plan. These requirements include publishing an annual report that is filed with the Secretary of Labor. *See* Section 103 of ERISA The annual report sets forth identifying information regarding the plan, the number of participants, the plan's funding arrangement and the plan's benefit arrangement. The annual report does not require any disclosure of the confidential, individualized health care and medical claims information sought by BISHCA. *See* ERISA Section 106, codified at 29 U.S.C. § 1026. Section 502(c)(2) of ERISA and the regulations thereunder set forth the penalties for failure to comply with ERISA's annual reporting requirements.

13. ERISA makes clear that the United States Department of Labor is the entity Congress contemplated and authorized to collect and analyze data regarding ERISA health plans. Section 513 of ERISA expressly gives the Secretary of Labor "authori[ty] to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to . . . welfare plans" such as the Plan. 29 U.S.C. § 1143(a). ERISA does not provide the States with authority to collect data from ERISA plans, but rather vests that authority in the Department of Labor.

14. Despite its considerable breadth, ERISA preemption does not extend to state laws that regulate only insurance, banking, or securities. *See* ERISA § 514(b)(2)(A), codified at 29 U.S.C. § 1144(b)(2)(A).

This exception to the general rule of ERISA preemption is known as the "Savings Clause." Under the Savings Clause, states are generally permitted to enact laws regulating only insurance. *See id.*

15. The "Deemer Clause" was also included in Section 514 of ERISA to ensure that the Savings Clause was not used as an end-run around ERISA's sweeping preemption provision. *See* ERISA § 514(b)(2)(B), codified at 29 U.S.C. § 1144(b)(2)(B). The Deemer Clause provides that a self-funded plan shall not "be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any state law purporting to regulate" insurance businesses. *Id.* The Deemer Clause makes clear that a state law will not avoid ERISA preemption by merely deeming an employee benefit plan to be an insurer.

16. Nothing in ERISA permits a State to deem a self-insured employee welfare benefit plan or those providing administrative services to such a plan to be an insurance company so that it can require reporting of confidential, personal medical information to create its own proprietary health care database.

C. BISHCA and the Regulation

17. BISHCA is a Vermont state agency which, according to its website, "provid[es] a single point of access for consumer complaint resolution, enforcement authority, and legislative contact on issues affecting financial and health care services in Vermont."

http://www.bishca.state.vt.us/ (last visited Aug. 7, 2011). The Division of Health Care Administration, one of BISHCA's divisions, "regulates and monitors key sectors of Vermont's health care system to ensure that all Vermonters have access to health care that is affordable and meets accepted standards for quality." http://www.bishca.state.vt.us/health-care/health-care-administration (last visited Aug. 9, 2011). The Defendant is the Commissioner of BISHCA.

18. The state of Vermont has enacted 18 V.S.A. § 9410 (the "Statute") in its effort to regulate heath care administration. The Statute calls for BISHCA to create a "unified health care database," so that the Commissioner of BISHCA can carry out certain duties. *See* 18 V.S.A. § 9410(a)(1). These duties include: 1) determining the capacity and distribution of existing resources; 2) identifying health care needs and informing health care policy; 3) evaluating the effectiveness of intervention programs on improving patient outcomes; 4) comparing costs between various treatment settings and approaches; 5) providing information to consumers and purchasers of health care; and 6) improving the quality and affordability of patient health care and health care coverage. *See* 18 V.S.A. § 9410(a)(1)(A)-(F). These goals have nothing to do with regulating insurance but are, instead, directly aligned with the stated mission of BISHCA's Division of Health Care Administration. BISHCA is also granted enforcement responsibilities under the Statute.

19. Pursuant to the Statute, BISHCA promulgated Regulation H-2008-01 (the "Regulation") to implement the creation of a "unified health care data base." The Regulation states that "[t]he purpose of this rule is to set forth the requirements for the *submission of health care claims data, member eligibility data, and other information relating to health care* provided to Vermont residents or by Vermont health care providers and facilities by health insurers, managed care organizations, *third party administrators,* pharmacy benefit managers and others to [BISHCA] . . . and conditions for the use and dissemination of such claims data . . consistent with the purposes of 18 V.S.A. § 9410." *See* Regulation Section 1 (emphasis added).

20. In furtherance of this purpose, the Regulation requires "Health Insurers" to "regularly submit *medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care* provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non residents in specified electronic format to [BISHCA]." *See* Regulation Section 4(A) (emphasis added).

21. The Regulation broadly defines "Health Insurer" to include any "third party administrator . . . and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by

Vermont health care providers and facilities. The term may also include . . . any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities." *See* Regulation § 3(X). By its terms, the definition includes plan administrators, like Liberty Mutual, and third party administrators, like BCBSMA.

22. Accordingly, the Regulation requires Liberty Mutual and BCBSMA to annually report the Plan's private health care data and records of individuals' medical treatment to BISHCA.

D. The Issuance of the BISHCA Subpoena

23. BISHCA has repeatedly attempted to apply the Statute and Regulation to Liberty Mutual's ERISA-governed Plan. BISHCA has recently made several demands that Liberty Mutual and BCBSMA report the Plan's medical claims data. The information sought includes Plan participants' and beneficiaries' name, gender, date of birth, city zip code, social security number, diagnosis and procedure code, type of bill paid, amount charged, the co-payment or coinsurance amount, and drug code, among other information. *See* Regulation, at Appendix C-1.

24. In late May 2011, BCBSMA informed Liberty Mutual that BISHCA was being "very aggressive" in its efforts to enforce the claims data reporting Regulation and was pressuring BCBSMA to report the claims data for Liberty Mutual's Plan.

25. Both Liberty Mutual and BCBSMA have made numerous attempts to persuade BISHCA to abandon its efforts to apply the Regulation to the Plan. On June 6, 2011, Mary Connolly, the Vice President of Benefits at Liberty Mutual, and Liberty Mutual's Counsel Nancy L. Keating, spoke with Clifford Peterson, General Counsel for the Health Care Division of BISHCA, regarding the Vermont reporting rules and the issue of ERISA preemption. During that discussion, Mr. Peterson indicated that BISHCA would likely take enforcement action against BCBSMA if it failed to report the individual medical records and data of Plan participants and beneficiaries in the precise manner demanded by BISHCA. Liberty Mutual requested that BISHCA reconsider its insistence that the TPA report confidential health care information and participant medical records.

26. Subsequently, Jack Myers of BCBSMA communicated to Ms. Connolly that BISCHA "was about to take imminent action against" BCBSMA if it failed to submit the specific information, records and data demanded by BISCHA regarding Plan participants and beneficiaries.

27. On July 29, 2011, Ms. Connolly and Ms. Keating again spoke to BISHCA General Counsel Clifford Peterson and informed him that Liberty Mutual would continue to instruct BCBSMA not to report the claims data to BISHCA as it was inconsistent with the requirements of ERISA, and BISHCA had no right to compel a self-insured medical plan to

disclose confidential health care information so BISHCA could create a health care database, because the Regulation was preempted by ERISA. Mr. Peterson responded that ERISA did not preempt the Vermont reporting rules.

28. Subsequently, on August 5, 2011, the Defendant served a subpoena on BCBSMA and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.[1] (the "Subpoena"). *See* Exhibit A.

29. The Subpoena demands that the TPA produce "Eligibility files for the following months of incurred service for 2011: April, May, June"; "Medical claim files for the following months of incurred service for 2011: January, April, May, June"; and "Pharmacy claim files for the following months of incurred service for 2011: April, May, June." The data demanded in the Subpoena includes personal identifying information regarding individual Plan participants' and beneficiaries' medical treatment, including Plan member name, gender, date of birth, city zip code, social security number, diagnosis and procedure code, type of bill paid, amount charged, co-payment or coinsurance amount, and drug code, among other items of information.

30. The Subpoena states that "*the files which precede the June filing period are overdue to the*

---

[1] Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. does not provide services to the Plan, nor has the Plan provided medical records or data to that entity.

Department, and the June filings are due by July 31, 2011." (emphasis added).

31. The Subpoena further states that "[p]ursuant to 8 V.S.A. § 13(b), a person who fails or refuses to produce papers or records . . . *may be assessed a penalty by the Commissioner of not more than $2,000.00 for each day* of noncompliance and proceeded against as provided in the Administrative Procedure act, and that person's *authority to do business may be suspended* for not more than six months." (emphasis added).

E. The Controversy Between the Parties

32. Liberty Mutual, as the Plan administrator, has repeatedly resisted BISHCA's attempt to require the reporting or other disclosure of the confidential information, records, and data of Plan participants and beneficiaries, for three primary reasons.

33. First, the Statute and Regulation are preempted by ERISA. Specifically, the Statute and Regulation impose a new reporting regime on self-funded medical plans that requires reporting and disclosure different in kind and in scope from what is imposed under ERISA. As such, the Statute and Regulation are an attempt to intrude upon the uniform and exclusive regulation of employee benefit plans that Congress provided under ERISA. BISHCA has attempted to avoid ERISA's preemptive effect by defining "Health Insurers" to include plan administrators and third party administrators. However, this

is nothing more than a legal fiction designed to allow BISHCA to improperly seek the confidential health care information, private medical records, and data of the Plan's participants and beneficiaries. Significantly, ERISA's Deemer Clause expressly rejects states' attempts to classify employee benefit plans as insurance companies in order to regulate them. BISHCA's attempt to treat Liberty Mutual and BCBSMA as "health insurers" is further belied by the fact that no Vermont resident without ties to Liberty Mutual Group Inc. and its subsidiaries can purchase insurance under the Plan.

34. Second, providing the Plan's claims data to BISHCA under the Statute and Regulation could constitute a violation of Liberty Mutual's ERISA fiduciary duties. The duties outlined in Section 404 of ERISA compel Liberty Mutual to safeguard against the type of detailed and intrusive reporting regime being imposed by BISHCA, particularly because BISHCA may release claims data to various third parties who request such data. *See* Regulation Section 9. Quite simply, the Plan may not be administered at the expense of the Plan and its participants in order to develop a health care database so that the State of Vermont can best determine how health care should be provided to residents.

35. Third, the Plan owns the claims data that BISHCA seeks, and Liberty Mutual Group Inc. and its subsidiaries, as a national employer, has designed the Plan to meet its own competitive needs in the marketplace. Accordingly, BISHCA is not entitled to

information related to the Plan design, including which claims the Plan does and does not cover or what a member's required coinsurance or copayments may be under the Plan, nor is it entitled to information relating to a participant's confidential medical claims information. BISHCA is similarly not entitled to compel the Plan's service providers (like BCBSMA) to report such information, irrespective of whether that individual is or is not a Vermont resident, since the service providers have no right to release the data to BISHCA without Liberty Mutual's consent.

COUNT I
ERISA Section 502(a)(3)

36. Plaintiff re-alleges and incorporates by reference all preceding allegations in this Complaint as though fully set forth in this Count I.

37. Section 502(a)(3) of ERISA provides that "[a] civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan."

38. There exists an actual controversy between Liberty Mutual and Defendant, which controversy can be resolved by a judgment of this Court.

39. Defendant subpoenaed the TPA demanding it turn over confidential health care information and

private medical records and data of Liberty Mutual's Plan participants and beneficiaries, and threatening the TPA with substantial fines and loss of its ability to do business in Vermont if it does not comply with the subpoena. The TPA has indicated that absent preliminary injunctive relief from this Court, the TPA will be forced to, and will, comply with the Subpoena and turn over the medical records and data being demanded.

40. Liberty Mutual, as Plan administrator and named fiduciary, therefore sues under Section 502(a)(3) of ERISA seeking a declaratory judgment and to enjoin Defendant's attempt to force the TPA to produce the subpoenaed information because Defendant's actions, and the Regulation and 18 V.S.A. § 9410, each violate and are preempted by ERISA.

41. Plan participants and beneficiaries who are Vermont residents, as well as the Plan and its fiduciaries, will suffer irreparable harm if enforcement of the Subpoena is not preliminarily and permanently enjoined.

WHEREFORE, Liberty Mutual respectfully requests that this Court:

A. Declare that BISHCA' s Regulation H-2008-01 and the Vermont health care database statute set forth in 18 V.S.A. § 9410 are preempted by ERISA to the extent they require the reporting, production, or disclosure of any confidential health care information or medical records or data relating to the Plan or its participants and beneficiaries;

B. Preliminarily and permanently enjoin the Defendant from attempting to obtain, from the TPA or any other source, any medical records or data relating to the Plan or its participants and beneficiaries;

C. Award Liberty Mutual its reasonable attorney's fees and costs incurred in this action pursuant to ERISA Section 502(g); and

D. Grant such further equitable relief as may be deemed appropriate.

Dated: August 12th 2011 Respectfully submitted,

/s/ R. Jeffrey Behm

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VERIFICATION

I, Mary Connolly, have reviewed the allegations made in this Verified Complaint and swear and affirm under penalties of perjury of the laws of the United States of America that they are true and correct to the best of my knowledge and belief.

/s/ Mary Connolly
Mary Connolly
Vice President &
Manager of Benefits
Liberty Mutual
Insurance Company

Subscribed and sworn to
before me this 12 day of
August, 2011

/s/ Jeanne Morse
Notary Public [Notary Stamp]

EXHIBIT A

STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION

TO: Blue Shield of Massachusetts HMO Blue, Inc. AND Blue Cross and Blue Shield of Massachusetts, Inc.	))))	Docket No. 11-035-H

SUBPOENA

Pursuant to the authority contained in 8 V.S.A. §13, YOU ARE HEREBY DIRECTED TO PRODUCE to *Onpoint Health Data,* duly-appointed contractor of the Department of Banking, Insurance, Securities and Health Care Administration, located at 16 Association Drive, Manchester, Maine, 04351, THE INFORMATION, DATA, AND DOCUMENTS SPECIFIED IN THE ATTACHED EXHIBIT "A" on or before *August 10, 2011* and pursuant to the instructions in Exhibit "A." The data should be submitted in the same manner as previous submissions.

The terms "information, data, and documents" include, but are not limited to, all records and other tangible forms of expression, drafts or finished versions, originals, copies of annotated copies, however produced or stored (manually, mechanically, electronically or otherwise), including but not limited to books, papers, files, notes, correspondence, memoranda, ledger sheets, reports, telegrams, telexes,

facsimiles, telephone logs, contracts, agreements, calendars or date books, phone logs, bank statements, worksheets, computer files including electronic mail, software disk packs and other electronic media and the documents generated therefrom, microfilm, microfiche, and storage devices.

Pursuant to 8 V.S.A. § 13(b), a person who fails or refuses to produce papers or records for examination before the Commissioner, upon properly being ordered to do so, may be assessed an administrative penalty by the Commissioner of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and that person's authority to do business may be suspended for not more than six months.

Dated at Montpelier, Vermont this 2nd day of August, 2011.

By: /s/ S. W. Kimbell
STEPHEN W KIMBELL,
COMMISSIONER
Vermont Department of
Banking, Insurance,
Securities and Health
Care Administration

EXHIBIT A

Instructions

The following files for Vermont enrollees ("the files") are due to the Vermont Department of Banking,

Insurance, Securities and Health Care Administration ("the Department") to meet ongoing reporting requirements of the State's Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) as specified in State Reg. H-2008-01. The files which precede the June filing period are overdue to the Department, and the June filings are due by July 31, 2011 and must be electronically filed with Onpoint Health Data, the State of Vermont's designated contractor.

All files must meet the same filing requirements and be electronically filed in the same manner as the historic production files that have already been submitted to Onpoint Health Data by Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. for preceding filing periods.

Following production of these files, Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. are to resume timely submissions of monthly production files.

Data To Be Produced

The files are:

1. Blue Cross Blue Shield of Massachusetts, Inc.
    - Eligibility files for the following months of incurred services for 2011: April, May, June

- Medical claims files for the following months of incurred services for 2011: January, April, May, June
- Pharmacy claims files for the following months of incurred services for 2011: April, May, June

2. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.

- Eligibility files for the following months of incurred services for 2011: April, May, June
- Medical claims files for the following months of incurred services for 2011: January, March, April, May, June
- Pharmacy claims files for the following months of incurred services for 2011: April, May, June

Title 18: Health

Chapter 220: GREEN MOUNTAIN CARE BOARD

Sub-Chapter 001: Green Mountain Care Board

18 V.S.A. § 9374. Board membership; authority

§ 9374. Board membership; authority

* * *

(i) In addition to any other penalties and in order to enforce the provisions of this chapter and empower the Board to perform its duties, the Chair of the Board may issue subpoenas, examine persons, administer oaths, and require production of papers and records. Any subpoena or notice to produce may be served by registered or certified mail or in person by an agent of the Chair. Service by registered or certified mail shall be effective three business days after mailing. Any subpoena or notice to produce shall provide at least six business days' time from service within which to comply, except that the Chair may shorten the time for compliance for good cause shown. Any subpoena or notice to produce sent by registered or certified mail, postage prepaid, shall constitute service on the person to whom it is addressed. Each witness who appears before the Chair under subpoena shall receive a fee and mileage as provided for witnesses in civil cases in Superior Courts; provided, however, any person subject to the Board's authority shall not be eligible to receive fees or mileage under this section.

(j) A person who fails or refuses to appear, to testify, or to produce papers or records for examination before the Chair upon properly being ordered to do so may be assessed an administrative penalty by the Chair of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and the Chair may recommend to the appropriate licensing entity that the person's authority to do business be suspended for up to six months.

No. 79. An act relating to health insurance, Medicaid, the Vermont Health Benefit Exchange, and the Green Mountain Care Board.

(H.107)

It is hereby enacted by the General Assembly of the State of Vermont:

* * *

Sec. 40. 18 V.S.A. § 9410 is amended to read:

§ 9410. HEALTH CARE DATABASE

(a)(1) The ~~commissioner~~ *Board* shall establish and maintain a unified health care database to enable the ~~commissioner and the Green Mountain Care board~~ *Commissioner and the Board* to carry out their duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) ~~Determining~~ *determining* the capacity and distribution of existing resources.;

(B) ~~Identifying~~ *identifying* health care needs and informing health care policy.;

(C) ~~Evaluating~~ *evaluating* the effectiveness of intervention programs on improving patient outcomes.;

(D) ~~Comparing~~ *comparing* costs between various treatment settings and approaches.;

(E) ~~Providing~~ *providing* information to consumers and purchasers of health care.; *and*

(F) ~~Improving~~ *improving* the quality and affordability of patient health care and health care coverage.

(2)(A) The program authorized by this section shall include a consumer health care price and quality information system designed to make available to consumers transparent health care price information, quality information, and such other information as the ~~commissioner~~ *Board* determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.

(B) ~~The commissioner shall convene a working group composed of the commissioner of mental health, the commissioner of Vermont health access, health care consumers, the office of the health care ombudsman, employers and other payers, health care providers and facilities, the Vermont program for quality in health care, health insurers, and any other individual or group appointed by the commissioner to advise the commissioner on the development and implementation of the consumer health care price and quality information system~~.

~~(C)~~ The ~~commissioner~~ *Commissioner* may require a health insurer covering at least five percent of the lives covered in the insured market in this state to file with the ~~commissioner~~ *Commissioner* a consumer health care price and quality information plan in accordance with rules adopted by the ~~commissioner~~ *Commissioner*.

~~(D)~~*(C)* The ~~commissioner~~ *Board* shall adopt such rules as are necessary to carry out the purposes of this subdivision. The ~~commissioner's~~ *Board's* rules may permit the gradual implementation of the consumer health care price and quality information system over time, beginning with health care price and quality information that the ~~commissioner~~ *Board* determines is most needed by consumers or that can be most practically provided to the consumer in an understandable manner. The rules shall permit health insurers to use security measures designed to allow subscribers access to price and other information without disclosing trade secrets to individuals and entities who are not subscribers. The ~~regulations~~ *rules* shall avoid unnecessary duplication of efforts relating to price and quality reporting by health insurers, health care providers, health care facilities, and others, including activities undertaken by hospitals pursuant to their community report obligations under section 9405b of this title.

(b) The database shall contain unique patient and provider identifiers and a uniform coding system, and shall reflect all health care utilization, costs, and resources in this ~~state~~ *State*, and health care utilization and costs for services provided to Vermont residents in another ~~state~~ *State*.

(c) Health insurers, health care providers, health care facilities, and governmental agencies shall file reports, data, schedules, statistics, or other information determined by the ~~commissioner~~ *Board*

to be necessary to carry out the purposes of this section. Such information may include:

(1) health insurance claims and enrollment information used by health insurers;

(2) information relating to hospitals filed under subchapter 7 of this chapter (hospital budget reviews); and

(3) any other information relating to health care costs, prices, quality, utilization, or resources required *by the Board* to be filed ~~by the commissioner~~.

(d) The ~~commissioner~~ *Board* may by rule establish the types of information to be filed under this section, and the time and place and the manner in which such information shall be filed.

(e) Records or information protected by the provisions of the physician-patient privilege under 12 V. S.A. § 1612(a), or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the protected person.

(f) The ~~commissioner~~ *Board* shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner.

(g) Any person who knowingly fails to comply with the requirements of this section or rules adopted pursuant to this section shall be subject to an administrative penalty of not more than $1,000.00 per violation. The ~~commissioner~~ *Board* may impose an

administrative penalty of not more than $10,000.00 each for those violations the ~~commissioner~~ *Board* finds were willful. In addition, any person who knowingly fails to comply with the confidentiality requirements of this section or confidentiality rules adopted pursuant to this section and uses, sells, or transfers the data or information for commercial advantage, pecuniary gain, personal gain, or malicious harm shall be subject to an administrative penalty of not more than $50,000.00 per violation. The powers vested in the ~~commissioner~~ *Board* by this subsection shall be in addition to any other powers to enforce any penalties, fines, or forfeitures authorized by law.

(h)(1) All health insurers shall electronically provide to the ~~commissioner~~ *Board* in accordance with standards and procedures adopted by the ~~commissioner~~ *Board* by rule:

(A) their health insurance claims data, provided that the ~~commissioner~~ *Board* may exempt from all or a portion of the filing requirements of this subsection data reflecting utilization and costs for services provided in this ~~state~~ State to residents of other states;

(B) cross-matched claims data on requested members, subscribers, or policyholders; and

(C) member, subscriber, or policyholder information necessary to determine third party liability for benefits provided.

(2) The collection, storage, and release of health care data and statistical information that is subject to the federal requirements of the Health Insurance Portability and Accountability Act ("HIPAA") shall be governed exclusively by the ~~rules~~ *regulations* adopted thereunder in 45 ~~CFR~~ *C.F.R.* Parts 160 and 164.

(A) All health insurers that collect the Health Employer Data and Information Set (HEDIS) shall annually submit the HEDIS information to the ~~commissioner~~ *Board* in a form and in a manner prescribed by the ~~commissioner~~ *Board*.

(B) All health insurers shall accept electronic claims submitted in Centers for Medicare and Medicaid Services format for UB-92 or HCFA-1500 records, or as amended by the Centers for Medicare and Medicaid Services.

(3)(A) The ~~commissioner~~ *Board* shall collaborate with the ~~agency of human services~~ *Agency of Human Services* and participants in ~~agency of human services~~ *the Agency's* initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of ~~limited use~~ *limited-use* data sets, the criteria and procedures to ensure that HIPAA compliant ~~limited use~~ *limited-use* data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size.

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the ~~commissioner~~ *Board* may prescribe by ~~regulation~~ rule, the Vermont ~~program for quality in health care~~ *Program for Quality in Health Care* shall have access to the unified health care database for use in improving the quality of health care services in Vermont. In using the database, the Vermont ~~program for quality in health care~~ *Program for Quality in Health Care* shall agree to abide by the rules and procedures established by the ~~commissioner~~ *Board* for access to the data. The ~~commissioner's~~ *Board's* rules may limit access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

(D) Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contains direct personal identifiers. For the purposes of this section, "direct personal identifiers" include information relating to an individual that contains primary or obvious identifiers, such as the

individual's name, street address, e-mail address, telephone number, and Social Security number.

(i) On or before January 15, 2008 and every three years thereafter, the ~~commissioner~~ *Commissioner* shall submit a recommendation to the ~~general assembly~~ *General Assembly* for conducting a survey of the health insurance status of Vermont residents.

(j)(1)) As used in this section, and without limiting the meaning of subdivision 9402(8) of this title, the term "health insurer" includes:

(A) any entity defined in subdivision 9402(8) of this title;

(B) any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to *a* Vermont resident, and health care provided by Vermont health care providers and facilities required to be filed by a health insurer under this section;

(C) any health benefit plan offered or administered by or on behalf of the ~~state~~ *State* of Vermont or an agency or instrumentality of the ~~state~~ *State*; and

(D) any health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government.

(2) The ~~commissioner~~ *Board* may adopt rules to carry out the provisions of this subsection, including

~~standards and procedures requiring the registration of persons or entities not otherwise licensed or registered by the commissioner and~~ criteria for the required filing of such claims data, eligibility data, provider files, and other information as the ~~commissioner~~ *Board* determines to be necessary to carry out the purposes of this section and this chapter.

* * *

Sec. 50. TRANSFER OF POSITIONS

(a) On or before July 1, 2013, the Department of Financial Regulation shall transfer positions numbered 290071, 290106, and 290074 and associated funding to the Green Mountain Care Board for the administration of the health care database.

(b) On or before July 1, 2013, the Department of Financial Regulation shall transfer position number 297013 and associated funding to the Agency of Administration.

(c) On or after July 1, 2013, the Department of Financial Regulation shall transfer one position and associated funding to the Department of Health for the purpose of administering the hospital community reports in 18 V.S.A. § 9405b. The Department of Financial Regulation shall continue to collect funds for the publication of the reports pursuant to 18 V.S.A. § 9415 and shall transfer the necessary funds annually to the Department of Health.

* * *

Sec. 52. REPEALS

(a) 8 V.S.A. § 4080f (Catamount Health) is repealed on January 1, 2014, except that current enrollees may continue to receive transitional coverage from the Department of Vermont Health Access as authorized by the Centers on Medicare and Medicaid Services.

(b) 18 V.S.A. § 708 (health information technology certification process) is repealed on passage.

(c) 33 V.S.A. chapter 19, subchapter 3a (Catamount Health Assistance) is repealed January 1, 2014, except that current enrollees may continue to receive transitional coverage from the Department of Vermont Health Access as authorized by the Centers for Medicare and Medicaid Services.

(d) 33 V.S.A. § 2074 (VermontRx) is repealed on January 1, 2014.

(e) 18 V.S.A. § 9403 (Division of Health Care Administration) is repealed on July 1, 2013.

(f) 8 V.S.A. § 4089w (Health Care Ombudsman) is repealed on January 1, 2014.

* * *

AMICUS CURIAE BRIEF

Supreme Court, U.S.
FILED
MAY 19 2015
OFFICE OF THE CLERK

No. 14-181

In the Supreme Court of the United States

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD, PETITIONER

v.

LIBERTY MUTUAL INSURANCE COMPANY

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.*, preempts, as applied to self-insured health benefit plans or their third-party administrators, a Vermont statute that requires healthcare payers to report claims and healthcare-services data to a state agency.

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In the Supreme Court of the United States

No. 14-181

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD, PETITIONER

v.

LIBERTY MUTUAL INSURANCE COMPANY

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

INTEREST OF THE UNITED STATES

This brief is submitted in response to the order of this Court inviting the Solicitor General to express the views of the United States. In the view of the United States, the petition for a writ of certiorari should be denied.

STATEMENT

1. The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, is designed to "protect * * * the interests of participants in employee benefit plans and their beneficiaries * * * by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C.

1001(b). The statute requires every plan to be established and maintained pursuant to a written instrument and to have named fiduciaries who have authority to control and manage the administration of the plan and its assets. 29 U.S.C. 1102(a)(1), 1103(a). With specific exceptions, ERISA preempts "any and all State laws insofar as they * * * relate to any employee benefit plan" covered by the statute. 29 U.S.C. 1144(a).

Various provisions of ERISA impose reporting requirements on plans. Plan administrators generally must file detailed financial and actuarial information with the Secretary of Labor (Secretary). See 29 U.S.C. 1021(b), 1023, 1024(a). In addition, plan administrators must file reports with the Secretary when certain events occur, such as when a pension plan winds up its affairs, 29 U.S.C. 1021(c), or when the employer fails to make a payment required under ERISA's minimum funding standard, 29 U.S.C. 1021(d). Under 29 U.S.C. 1024(a)(3), however, the Secretary has exempted welfare plans from most reporting requirements. See 29 C.F.R. 2520.103-1, 2520.104-20, 2520.104-44. Only when a welfare plan's assets are held in trust must it provide the Secretary with financial information. 29 C.F.R. 2520.103-1.

In addition, the Secretary has broad authority to investigate health plans for enforcement purposes. See 29 U.S.C. 1132(a)(5) (authority to enforce statutory provisions or enjoin violations); 29 U.S.C. 1134 (authority to investigate). Such investigations typically entail the inspection of plan documents, administrative contracts, and claims records to determine whether breaches of fiduciary duty or violations of the claims-processing rules have occurred or whether a

plan is out of compliance with other legal requirements. ERISA also authorizes the Secretary "to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans." 29 U.S.C. 1143(a)(1).[1]

2. a. A Vermont statute requires the Green Mountain Care Board (Board), a state agency, to maintain a healthcare-information database. Vt. Stat. Ann. tit. 18, § 9402(17) (2012), *id.* § 9410(a) (Supp. 2014) (Database Statute). The database is designed to help the state government achieve a variety of health-policy objectives, including "identifying health care needs," "comparing costs between various treatment settings and approaches," "determining the capacity and distribution of existing resources," and "providing information to consumers and purchasers of health care." *Id.* § 9410(a)(1) (Supp. 2014).

The Database Statute requires "[h]ealth insurers" and other entities to submit to the Board "reports, data, schedules, statistics, or other information" that the Board finds necessary. § 9410(c)-(d) (Supp. 2014). In particular, it authorizes the Board to require health insurers to file "health insurance claims and enrollment information" and "any other information relating to health care costs, prices, quality, utilization, or resources." *Id.* § 9410(c)(1) and (3) (Supp. 2014). The Board is authorized to enforce the Database Statute

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[1] The Secretary has informed this Office that, in aid of his authority to ensure compliance with ERISA's fiduciary standards and claims-processing rules, the Secretary is currently considering undertaking a rulemaking to require health plans to report more detailed information about the cost of benefits, utilization of medical services, and plan administration.

through the imposition of financial penalties, *id.* § 9410(g) (Supp. 2014), and through its general subpoena power, Vt. Stat. Ann. tit. 18, § 9374(i) (Supp. 2014); *id.* § 9412(a) (2012).

In 2008, the Commissioner of the Vermont Department of Banking, Insurance, Securities and Health Care Administration (Commissioner), who had authority to enforce the Database Statute until June 7, 2013, promulgated a regulation to implement the statute. See Reg. H-2008-01, 21-040-021 Vt. Code R. (2008) (Database Regulation); see also 2013 Vt. Acts & Resolves 724-727 (transferring authority to administer statute to the Board). The Database Regulation provides that "[h]ealth insurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information." § 4(D). It includes requirements for how the data must be formatted and when it must be submitted, as well as confidentiality protections. *Id.* §§ 5-8. The Database Regulation defines "[h]ealth insurer" to include any "third party administrator" and "to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities." *Id.* § 3(X). It exempts health insurers with fewer than 200 enrolled or covered members from the reporting requirements (although they may voluntarily comply). *Id.* § 3(Ab) and (As).

b. Respondent is the named fiduciary and administrator of an ERISA self-insured health plan covering 80,000 individuals, 137 of whom are Vermont residents. Pet. App. 7, 50. A self-insured plan is one in which the plan sponsor pays claims out of its own assets, rather than contracting with an insurance

company to pay claims under an insurance policy. *Id.* at 7. Self-insured plans may be administered by a third party, however, and respondent has contracted with Blue Cross Blue Shield of Massachusetts, Inc. (Blue Cross) to serve as the plan's third-party administrator in Vermont. In that capacity, Blue Cross handles administrative functions such as claims processing, bill review, and claims payments. *Id.* at 8, 50-51.

In August 2011, the Commissioner issued a subpoena to Blue Cross, seeking eligibility information and medical- and pharmacy-claims files for Vermont residents covered by respondent's plan. Pet. App. 8-9. Respondent, believing that the request was preempted by ERISA, instructed Blue Cross not to comply with the subpoena. *Id.* at 9.

3. Respondent filed suit in the United States District Court for the District of Vermont against the Commissioner.[2] Pet. App. 48. Respondent sought a declaratory judgment that the Database Statute and Database Regulation "are preempted by ERISA to the extent they require the reporting, production, or disclosure of any confidential health care information or medical records or data relating to [respondent's health benefit] [p]lan or its participants and beneficiaries." Cert. Reply Br. App. 16. Respondent also sought to enjoin the Commissioner "from attempting to obtain, from [Blue Cross] or any other source, any medical records or data relating to the [p]lan or its participants and beneficiaries." *Id.* at 17.

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[2] Vermont's Department of Banking, Insurance, Securities, and Health Care Administration was renamed the Department of Financial Regulation in 2012. 2012 Vt. Acts & Resolves 57; see Pet. App. 49 n.1.

The Commissioner moved to dismiss the complaint for lack of standing and, alternatively, on the merits. D. Ct. Doc. 15, at 1 (Sept. 15, 2011). Respondent moved for summary judgment. D. Ct. Doc. 35 (June 25, 2012). Respondent argued generally that, due to their asserted complexity, the Vermont reporting requirements impose burdens on the administration of its ERISA plan, but respondent did not submit any affidavits describing or quantifying the alleged burdens. See D. Ct. Docs. 35-37 (June 25, 2012).

The district court concluded that respondent had sufficiently alleged standing but granted the Commissioner's motion to dismiss on the merits and denied respondent's motion for summary judgment. Pet. App. 48-80. The court held that although "[c]ompliance with the reporting requirements * * * may have some indirect effect on health benefit plans," the possible "effect is so peripheral that the regulation cannot be considered an attempt to interfere with the administration or structure of a welfare benefit plan." *Id.* at 78. The court emphasized that respondent had "not submitted any information about any actual burden suffered by itself or [Blue Cross] in producing this information." *Id.* at 73 n.5.

4. Respondent appealed. The Acting Secretary of Labor filed an amicus brief in favor of the Commissioner in the court of appeals, arguing that ERISA does not preempt the Database Statute or Database Regulation. In a divided decision, the court of appeals reversed, holding that the Vermont reporting requirements are preempted. Pet. App. 1-47.[3]

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[3] Every member of the panel agreed that respondent has standing. See Pet. App. 9-10; *id.* at 30 (Straub, J., dissenting in part and concurring in part).

a. The court of appeals began by explaining that under this Court's construction of ERISA's preemption provision, 29 U.S.C. 1144(a), "a state law is preempted if 'it [1] has a connection with or [2] reference to [an ERISA] plan.'" Pet. App. 14 (brackets in original) (quoting *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). The court of appeals further explained, however, that this Court has made clear that the preemption provision's "relate to" requirement cannot be read literally, because "if the phrase 'were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course.'" *Id.* at 19 (quoting *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (*Travelers*)). The court of appeals understood this Court's decisions to teach that "'state statutes that mandate[] employee benefit structures *or their administration*' have a 'connection with' ERISA plans and are therefore preempted." *Id.* at 20 (brackets in original) (quoting *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 328 (1997) (*Dillingham*)).

Applying those principles, the court of appeals held that "the reporting requirements of the Vermont statute and regulation have a 'connection with' ERISA plans (though no 'reference to' them)" and are therefore preempted. Pet. App. 23 (footnote omitted). Although the court cautioned that "[n]ot every state law imposing a reporting requirement is preempted," *id.* at 24, it determined that "the reporting mandated by the Vermont statute and regulation is burdensome, time-consuming, and risky," *id.* at 25. The court noted that Vermont could change the requirements at any

time, *id.* at 27, and it postulated that if respondent were subject to "one of several or a score of uncoordinated state reporting regimes," the burden would be "obviously intolerable," *id.* at 25.[4]

b. Judge Straub dissented in relevant part. Pet. App. 30-47 (dissenting in part and concurring in part). Adopting the view of the Acting Secretary's amicus brief, he concluded that the Vermont reporting requirements do not have a sufficient "connection with" ERISA plans to fall under the preemption provision. *Id.* at 47. Judge Straub explained that in analyzing the preemption issue, "[t]he distinction between general administration and administration of plans, claims, and benefits is important." *Id.* at 42. "Many state laws," he continued, "may have an impact on the administration of an ERISA plan—for example, a work-place safety law, a prevailing wage law, or a law that requires companies to report employment data." *Ibid.* Although "[s]uch laws may impose additional costs," he concluded, "none of these laws impact *how benefits are administered to beneficiaries* and, therefore, they are not preempted by ERISA." *Ibid.* (citing *Dillingham*, 519 U.S. at 319). Judge Straub also found that "on the record before [the court,]" no basis existed to conclude that the Vermont reporting requirements would "hinder the national administration of employment benefit plans in any way," because

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[4] The court of appeals had no occasion to address whether its holding applies to insurance companies that insure ERISA plans. ERISA generally exempts from its preemption provision "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. 1144(b)(2)(A); see *Kentucky Ass'n of Health Plans, Inc.* v. *Miller*, 538 U.S. 329, 341-342 (2003).

"[n]o new records need be kept" to comply with the reporting obligation. *Id.* at 44; see *id.* at 41-42.

5. Approximately one month before the court of appeals issued its decision, a Vermont statute transferred the responsibilities for administering the reporting requirements from the Commissioner to the Chair of the Board. See p. 4, *supra*. The Commissioner did not file a motion for substitution of parties in the court of appeals, see Fed. R. App. P. 43(c)(2), and she subsequently filed a petition for rehearing, which was denied, Pet. App. 81-82. The Chair of the Board, however, filed the petition for a writ of certiorari in this Court. The petition states that the Chair was automatically substituted for the Commissioner under Rule 35.3 of the Rules of this Court. See Pet. ii.

DISCUSSION

The court of appeals erred in holding that the Vermont reporting requirements that respondent challenges are preempted by ERISA. Moreover, with the encouragement of the federal government, other States are establishing similar healthcare databases to help improve health outcomes for their citizens, and thus the question presented has national importance. But the decision of the court of appeals does not conflict with any decision of this Court or another court of appeals, and this Court's consideration of the question would likely be aided by further percolation in the courts of appeals. Accordingly, the petition for a writ of certiorari should be denied.

1. As a threshold matter, petitioner, the Chair of the Board, is an appropriate party to seek certiorari review in this case. The Chair assumed the relevant responsibilities for administering the Database Statute on June 7, 2013. See 2013 Vt. Acts & Resolves

724-727 (transferring authority to administer statute to Board). Respondent seeks prospective relief in the form of a declaratory judgment that enforcement of the reporting requirements against petitioner is preempted by ERISA and an injunction barring any attempt to "obtain, from [Blue Cross] or any other source, any medical records or data relating to the Plan or its participants and beneficiaries." Cert. Reply Br. App. 16-17.[5] Because the Chair of the Board now administers the reporting requirements and is the state official who seeks to enforce respondent's compliance with those requirements with respect to the subpoena in this case and would enforce its requirements in the future, prospective relief would properly run against the Chair, not the Commissioner.

Respondent appears to argue (Br. in Opp. 10-13) that because the subpoena that prompted this case was issued under the Commissioner's general subpoena power (at a time when the Commissioner administered the Database Statute), the Board's power to enforce the Database Statute is not at issue. But the Chair of the Board also has a general subpoena power, see Vt. Stat. Ann. tit. 18, § 9374(i)-(j) (Supp. 2014); *id.* § 9412(a) (2012), and there is no question that, going forward, the Board would invoke its own subpoena power to enforce the Database Statute and Database Regulation. See Cert. Reply Br. 11-13. The gravamen of the challenge here concerns the obligations imposed

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[5] The court of appeals characterized the injunctive relief sought by respondent as relating only to the subpoena issued to Blue Cross. See Pet. App. 9. The complaint, however, seeks an injunction against any enforcement of the reporting requirements for records or data relating to respondent's plan. See Cert. Reply Br. App. 17.

by the Database Statute and Database Regulation, not the particular source of subpoena authority. Accordingly, petitioner is correct that the Chair of the Board is the proper party to defend Vermont's reporting requirements at this point in the proceedings.[6]

2. ERISA does not preempt the Database Statute or Database Regulation.

a. ERISA's preemption provision, 29 U.S.C. 1144(a), provides that the statute "shall supersede any and all State laws insofar as they * * * relate to any employee benefit plan" covered by the statute. *Ibid.* This Court has long held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983) (footnote omitted); see, *e.g.*, *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 656 (1995).

A law has a "reference to" ERISA plans if the law "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 325-326 (1997). Barring such a reference, the Court "look[s] both to 'the objectives of the ERISA statute as a guide to the scope of the state law that

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[6] Supreme Court Rule 35.3 does not by its terms provide for automatic substitution in the situation in which statutory authority has been transferred from one government official to another. For that reason, it may have been the wiser course for petitioner to file a motion for substitution of parties in the court of appeals or in this Court. If this Court concludes that a motion is necessary, it could treat the petition for a writ of certiorari as encompassing such a motion.

Congress understood would survive,' as well as to the nature of the effect of the state law on ERISA plans," to "determine whether [the] state law has the forbidden connection" with ERISA plans. *Egelhoff* v. *Egelhoff ex rel. Breiner*, 532 U.S. 141, 147 (2001) (quoting *Dillingham*, 519 U.S. at 325). Where a state law unrelated to the basic purposes of ERISA operates in an area of traditional state regulation, such as "matters of health and safety," the fact that the law will have "some effect on the administration of ERISA plans" is insufficient for preemption, *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814, 816 (1997), particularly if the state law merely "alters the incentives, but does not dictate the choices, facing ERISA plans," *Dillingham*, 519 U.S. at 334.

b. Under the foregoing standards, the Vermont reporting requirements are not preempted. Respondent does not contest the court of appeals' holding that the requirements lack any "reference to" ERISA plans. Pet. App. 23 & n.9. The requirements apply to "all health care payers," not only to ERISA plans. *Id.* at 23 n.9. And the requirements could readily operate independently of the existence of ERISA plans (although excluding ERISA plans would render Vermont's database less comprehensive). See *Dillingham*, 519 U.S. at 326.

Accordingly, as the court of appeals correctly held, the key question in this case is whether the Vermont reporting requirements have the requisite "connection with" ERISA plans. In the view of the United States, Judge Straub was correct that, at least on the record before the court of appeals, the panel majority erred in holding that such a connection exists. That conclu-

sion follows both from the significant difference between the purpose of the Database Statute and ERISA's reporting requirements and from the lack of any record evidence that the Vermont statute will have more than an incidental effect on respondent's administration of its plan or its ability to comply with ERISA's requirements.

As discussed above, ERISA imposes a number of reporting requirements on plans, such as the submission of financial and actuarial information to the Secretary. See pp. 2-3, *supra*. Those requirements serve the basic purposes of ERISA: to prevent the "mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." *Dillingham*, 519 U.S. at 326-327 (quoting *Massachusetts* v. *Morash*, 490 U.S. 107, 115 (1989)). Any state-law reporting requirements serving the same functions would raise a substantial preemption question. Cf. *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 12-13 & n.7 (1987) (discussing *Standard Oil Co.* v. *Agsalud*, 633 F.2d 760 (9th Cir. 1980), summarily aff'd, 454 U.S. 801 (1981)). That is because such requirements would effectively alter the balance that Congress struck between, on the one hand, accountability and disclosure, and, on the other hand, administrative costs and complexity. See *Boggs* v. *Boggs*, 520 U.S. 833, 844 (1997) ("States are not free to change ERISA's structure and balance.").

The Vermont reporting requirements, however, have an entirely different focus. As the court of appeals explained, the information submitted to the Board enables it to populate a database that is designed as a tool to assess and improve healthcare

outcomes for Vermont residents. See Pet. App. 4-5 (citing Vt. Stat. Ann. tit. 18, § 9410(a)(1) (Supp. 2014)). The reporting requirements have nothing to do with ERISA's principal concerns with the soundness of plans and the actions of plan fiduciaries in administering plans and paying promised benefits. They are therefore "quite remote from the areas with which ERISA is expressly concerned." *Dillingham*, 519 U.S. at 330. For that reason, absent more, they do not fall within ERISA's preemptive scope. As this Court has explained, "in the field of health care, * * * there is no ERISA preemption without [a] clear manifestation of congressional purpose." *Pegram* v. *Herdich*, 530 U.S. 211, 237 (2000) (citing *Travelers*, 514 U.S. at 654-655).

The court of appeals nevertheless believed that the Database Statute and Database Regulation have the forbidden "connection with" ERISA plans because they require "reporting of health claims, pharmacy claims, *etc.*, information about the essential functioning of employee health plans." Pet. App. 29 n.13. But the mere fact that a state-law reporting obligation encompasses information about the operation of an ERISA plan does not suffice for preemption. In *De Buono*, for example, this Court held that a gross-receipts tax on patient services provided by a hospital operated by an ERISA plan was not preempted, see 520 U.S. at 809-810, 816, even though the administration of the tax required the hospital to file quarterly reports about its taxable gross receipts, see U.S. Amicus Br. at 2-3, *De Buono*, *supra* (No. 95-1594). The principal inquiry under the "connection with" prong of the ERISA preemption test is whether a state law "implicates an area of core ERISA concern." *Egel-*

hoff, 532 U.S. at 147. The fact that some information relevant to the operation of an ERISA plan is also relevant to non-ERISA areas of state legislative concern does not broaden the scope of ERISA preemption to include reporting requirements that have nothing to do with the financial soundness of ERISA plans or with their federal-law obligation to pay promised benefits.

That is not to say that *any* reporting obligation unrelated to the basic objectives of ERISA falls outside the scope of ERISA's preemption provision. As petitioner correctly acknowledges (Pet. 21), a state-law reporting obligation could in theory have effects on the administration of an ERISA plan that are "so acute," *De Buono*, 520 U.S. at 816 n.16, that preemption is warranted. See *Travelers*, 514 U.S. at 668; see also Br. in Opp. 19-20 & n.9. Moreover, in considering the effects of a state-law requirement, a court must consider the effects of a potential patchwork of state laws imposing different requirements, as the court of appeals held. See Pet. App. 29; see also *Egelhoff*, 532 U.S. at 149-150.

But in the posture of this case, no sound basis exists to conclude that the Vermont reporting requirements affect the administration of ERISA plans in a qualitatively different or more substantial way than "myriad state laws in areas traditionally subject to local regulation," such as health and safety, "which Congress could not possibly have intended to eliminate." *Travelers*, 514 U.S. at 668. As Judge Straub explained, "[o]n the record before [the court of appeals], there is no basis to find that the Vermont statute would cause [respondent] to increase its costs more than a *de* [*minimis*] amount to cover the cost of

sending information to the state, much less that it would cause a fiduciary to change a plan in any way." Pet. App. 40-41 (dissenting in part and concurring in part).

Respondent contends (Br. in Opp. 20) that the court of appeals' view of the burdens created by the reporting requirements "reflects a common sense assessment of the administrative realities of ERISA plans," because reporting requirements like the ones at issue here "require ERISA plans to provide states with specific information in a prescribed format and at prescribed intervals on every claim processed by the plans" and thus "directly affect those activities." But that supposition is not obvious without any factual support. If the plan has the necessary information readily at hand, for example, it is unlikely that merely reporting it to a state agency will significantly interfere with plan administration. Similarly, if Blue Cross already has procedures in place to submit the reports on behalf of other plans that Blue Cross insures or administers, it may entail little additional cost or administrative burden in submitting reports for respondent's plan. See Pet. App. 73 n.5 (noting that Blue Cross apparently provides the data on behalf of other plans).

In any event, as respondent acknowledges (Br. in Opp. 26), a state law that merely adds administrative costs to an ERISA plan is not preempted. After all, ordinary tax and employment laws can entail substantial administrative costs. To be preempted, the law must interfere with the way in which the plan is administered—for example, by requiring plan administrators to "familiarize themselves with state statutes" in order to determine to whom to pay benefits,

Egelhoff, 532 U.S. at 148-149. Without any showing that the requirements here have such an effect, the court of appeals was wrong to conclude that they are preempted.

c. Respondent briefly argues (Br. in Opp. 22-23) that the Database Statute and Database Regulation conflict with ERISA's requirement that fiduciaries follow plan documents, 29 U.S.C. 1104(a)(1)(D), because the plan documents in this case required respondent and Blue Cross to maintain the confidentiality of the medical records of participants and beneficiaries. See *Boggs*, 520 U.S. at 841 (holding that a state law is preempted by ERISA if it "conflicts with the provisions of ERISA or operates to frustrate its objects" regardless of Section 1144(a)'s applicability). But this Court has never suggested that the mere fact that a state law could conflict with a plan term is sufficient for preemption, and such a rule would effectively allow plan sponsors to evade any state law merely by adding a contrary plan term. See, *e.g.*, *FMC Corp.* v. *Holliday*, 498 U.S. 52, 54, 56-65 (1990) (analyzing whether ERISA preempted state law barring plan provision under the normal ERISA preemption framework rather than holding it preempted by Section 1104(a)(1)(D)). Respondent cites *Egelhoff*, 532 U.S. at 151 n.4, but the Court's only point in the cited discussion was that a state law that directly regulates the administration of a plan (there, the payment of benefits) is not saved from preemption if it permits a plan sponsor to expressly opt out of the law by amending plan language. That principle has no application here.[7]

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[7] In any event, the Vermont statute mandates that confidential information be "filed in a manner that does not disclose the identi-

3. Although the court of appeals erred in holding that the Vermont reporting requirements are preempted by ERISA, this Court's review of the question presented is not warranted at this time. The decision below does not squarely conflict with a decision of another court of appeals, and further percolation in the courts of appeals would likely aid this Court's ultimate review of the preemption issue.

a. Petitioner generally argues throughout the petition that the decision below conflicts with this Court's ERISA preemption decisions. Although the United States agrees that the court of appeals misapplied those general principles to the particular context of the recordkeeping requirements at issue here (see pp. 11-17, *supra*), that misapplication does not rise to the level of a direct conflict with this Court's precedent that would warrant review. This Court, in fact, has not considered a state law similar to the Vermont scheme.

Similarly, petitioner's contention (Pet. 14, 25, 31) that "[t]he Second Circuit embraced an expansive view of ERISA preemption" overstates the error of the court of appeals. The court made clear that it did

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ty of the protected person"; prohibits public disclosure of "direct personal identifiers," including names, addresses, and Social Security numbers; and requires submitters to comply with the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936. Database Statute § 9410(e) and (h)(3) (Supp. 2014). The federal Centers for Medicare and Medicaid Services provide Medicare claims data to Vermont for its database on the condition that Vermont protect the privacy of the information. See Pet. 22 n.3.

not believe that all reporting requirements would be preempted, see Pet. App. 24, and the court emphasized what it saw as the particularly burdensome nature of the requirements here, see *id.* at 25-29. Although the United States agrees with petitioner that the court of appeals lacked factual support for that conclusion, the decision below does not purport to rest on a significant expansion of ERISA preemption principles.

b. Petitioner also briefly contends (Pet. 32-33; Cert. Reply Br. 7-8) that the decision below conflicts with the Sixth Circuit's decision in *Self-Insurance Institute of America, Inc.* v. *Snyder*, 761 F.3d 631 (2014), petition for cert. pending, No. 14-741 (filed Dec. 18, 2014) (*Self-Insurance Institute*). In *Self-Insurance Institute*, the Sixth Circuit held that the application to ERISA plans of a Michigan tax on claims paid by, among others, ERISA plans to healthcare providers for services rendered was not preempted. See *id.* at 633, 641. The tax required the plans to submit quarterly returns to the state tax authority and to keep certain records. *Id.* at 633. The Sixth Circuit held that the tax law did not have the requisite "connection with" ERISA plans because the law did "not require a plan administrator to change how it administers the plan at all" but rather merely "create[d] work independent of the core functions of ERISA—as do permissible state property and employment laws." *Id.* at 635-636.

With respect to the Michigan law's recordkeeping requirements in particular, the Sixth Circuit held that although "Congress intended ERISA to preempt state laws providing for additional oversight with regard to the solvency of ERISA plans," that "basic conclu-

sion * * * does not mean that Congress intended federal law to bar states from imposing additional administrative burdens unrelated to the plans' core functions." 761 F.3d at 637-638. The Sixth Circuit pointed to *Travelers* and *De Buono* as decisions of this Court that upheld state laws that included record-keeping requirements. See *id.* at 638; see also p. 14, *supra*. And it noted that the contrary view would mean that "ERISA would preempt any state laws requiring ERISA-covered entities to submit income-tax returns, property-tax returns, or employment records." 761 F.3d at 638.

The Sixth Circuit rejected the plaintiff's reliance on the Second Circuit's decision in this case, characterizing the Second Circuit's analysis as a "literal approach" that swept too broadly. 761 F.3d at 639. But the Sixth Circuit also "distinguished" the decision below "on two other grounds." *Ibid.* First, the court said, the Michigan law's "reporting requirements are intimately related to a state tax—a traditional area of state concern that [courts] presume Congress left untouched"—whereas "the Vermont statute mandates reporting to build a healthcare database, a purpose," the court believed, that is "not entitled to the presumption." *Ibid.* Second, in the Sixth Circuit's view, the Vermont scheme "actually affects the administration of [ERISA] plans" because it requires an ERISA plan to choose between directing a third-party administrator to turn over records in violation of a plan document or to indemnify the administrator for violating state law. *Ibid.*

Although some tension exists between the analysis of the decision below and that of *Self-Insurance Institute*, that tension does not amount to a square conflict

warranting this Court's immediate review. The Sixth Circuit took pains to distinguish the decision below, and thus if a state law similar to Vermont's came before the Sixth Circuit, the State could not rely on *Self-Insurance Institute* as significant support for non-preemption. Indeed, the Sixth Circuit's opinion, if anything, seems to suggest that the result of the decision below was correct because "[t]he Vermont scheme actually affects the administration of the plans." 761 F.3d at 639. Although the United States disagrees with that dicta, it demonstrates that no square conflict exists over the question presented at this time.

c. The question presented is important, but in our view it does not require this Court's review at the present time, before any other court of appeals has had the opportunity to address a similar reporting scheme.

As petitioner explains (Pet. 26-31), the development of state healthcare claims databases has great potential to improve healthcare outcomes nationally.[8] For example, the federal Center for Medicare and Medicaid Innovation, which supports the development and testing of new healthcare payment and service-delivery models, funds a variety of state-conducted models, including models for "all payers," that rely on state data-collection efforts for evaluation purposes.

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[8] See, *e.g.*, Ctrs. For Medicare & Medicaid Servs., *Rate Review Cycle III Funding Opportunity: Frequently Asked Questions*, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rr-foa-faq-6-6-2013.html (last visited May 19, 2015); Ctrs. For Disease Control & Prevention, *CDC's Assessment Initiative Cooperative Agreement: New Hampshire*, http://www.cdc.gov/ai/states/nh.html (last visited May 19, 2015).

See 42 U.S.C. 1315a(a)(1) and (b)(2)(B). In evaluating a model, the Secretary of Health and Human Services (HHS) must analyze "the quality of care furnished under the model, * * * [and] the changes in spending under [Medicare, Medicaid and the Children's Health Insurance Program (CHIP)] by reason of the model." 42 U.S.C. 1315a(b)(4). In part because models may sometimes shift costs among different payers or have health effects that are not reflected in the Medicare, Medicaid, and CHIP databases, it is essential to the accuracy of some evaluations to be able to analyze state-level databases that include all payer claims. According to HHS, using incomplete data sets often impedes the government's ability to assess whether initiatives have achieved cost savings or improved quality. Relatedly, Congress, recognizing the importance of access to comprehensive claims data for healthcare evaluation purposes, has made Medicare data available to States that use claims data "to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use." 42 U.S.C. 1395kk.

Although federally created health claims databases exist for Medicare and federal employees, no federal agency has created an all-payer database that encompasses ERISA-covered plans along with other payers. For that reason, States are uniquely positioned to improve quality of care and to control costs through the collection and publication of claims data. If States are unable to acquire such data from self-insured ERISA healthcare plans, their databases will be significantly less comprehensive and thus not as useful in developing health policy at both the state and national

levels. See Pet. 29-30; Sec'y of Labor C.A. Amicus Br. 10; see also States Cert. Amicus Br. 3.

Although the question presented thus has substantial importance to the Nation's healthcare system, further percolation of the question presented among the courts of appeals is likely to prove helpful to the Court. In addition to furnishing the perspective of other courts of appeals on the legal issue, additional appellate decisions in this area may furnish this Court with more information to assess the impact of similar reporting requirements on the administration of ERISA plans generally. And because States in the First, Fourth, Sixth, Eighth, Ninth, and Tenth Circuits "have enacted legislation creating health-care data collection programs" similar to Vermont's scheme (States Cert. Amicus Br. 1 & n.3), it is reasonably likely that other circuits will have the opportunity to consider the question presented.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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